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# Informed Consent: A Right without a Remedy Examined through the Lens of Maternity Care

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# INFORMED CONSENT: A RIGHT WITHOUT A REMEDY EXAMINED THROUGH THE LENS OF MATERNITY CARE

KRISTEN ANN CURRAN<sup>\*</sup>

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## I. INTRODUCTION

The right to be secure in one's own person is a natural, fundamental right.<sup>1</sup> Many natural rights have been legally recognized, and legal mechanisms safeguard these rights by providing legal remedies to ensure that rights exist in a practical sense rather than as theoretical concepts.<sup>2</sup>

Consider, for example, the right to procreate.<sup>3</sup> In *Skinner v. Oklahoma*, the Court strongly characterized sterilization as a permanent deprivation of an important human right.<sup>4</sup> Almost sixty years later, in *Robinson v. Cutchin*, the United States District Court for the District of Maryland considered a case in which the plaintiff alleged that she was sterilized during a Cesarean section surgery without her consent.<sup>5</sup> In a cavalier manner at odds with the grave tone of the *Skinner* court, the *Robinson* court dismissed the plaintiff's case.<sup>6</sup> The *Robinson* court held that because Mrs. Robinson suffered no more pain or injury than was normal following a Cesarean section, her unconsented sterilization was not harmful and her subsequent infertility was no injury.<sup>7</sup> Furthermore, the court considered the dignity aspect of a battery action and found Mrs. Robinson's injury lacking; in effect, the court substituted its "judgment" for Mrs. Robinson's right to procreate.<sup>8</sup> Because Maryland only recognizes informed consent violations as negligence causes of action, not battery, and Mrs. Robinson

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1. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (holding that the right to bodily integrity is a universal human right).

2. See *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 163 (1803) (creating a legal remedy is the legal mechanism to defend against and remedy an invasion of a right).

3. See *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1942) (identifying procreation as a basic civil right of man because the ability to have children can have profound personal effects and determines the racial and social composition of future generations).

4. See *id.* at 541 (discussing the irreparable personal injury of sterilization and the insidious effects to society of the practice, particularly when used to conduct eugenics).

5. See *Robinson v. Cutchin*, 140 F. Supp. 2d 488, 490-91 (D. Md. 2001) (noting that although her consent to the Cesarean is undisputed, Mrs. Robinson did not consent to the tubal ligation procedure).

6. See *id.* at 493 (holding that Maryland does not recognize battery in informed consent cases and that Mrs. Robinson could not state a claim for negligence without suffering an injury).

7. See *id.* (noting that Mrs. Robinson did not even know she was infertile until twenty-one months after the surgery and that her only physical injury stemmed from the Cesarean to which she had consented).

8. See *id.* (explaining that since Mrs. Robinson had already born six children, she could not reasonably find sterilization offensive).

could not sustain negligence without a legally recognized injury, she was left without a cause of action or a legal remedy.<sup>9</sup> Without a remedy to assert against Dr. Cutchin's unconsented sterilization, Mrs. Robinson's right to procreate was quantified at six children.<sup>10</sup>

This Comment argues that the inadequacies of the informed consent doctrine fail to ensure the fundamental right to bodily integrity by analyzing pain management treatment during childbirth. Part II will examine the modern doctrine of informed consent and how it evolved, inquire into other areas of law to identify analogous injuries to inadequate informed consent, and discuss why maternity care is an excellent lens through which to analyze informed consent.<sup>11</sup> To demonstrate the limitations of informed consent law in America, this Comment analyzes the law through a hypothetical built on common maternity care practices and average patient experiences.<sup>12</sup> Part III analyzes the hypothetical scenario under the informed consent statutes of the states of New York, Washington, and Wisconsin.<sup>13</sup> Part IV discusses the policy implications of maintaining the status quo—which largely provides no legal remedy for the failure to obtain informed consent—and will recommend that states consider adopting informational standing to ensure the right to bodily integrity is not impinged.<sup>14</sup> Part V concludes that as the modern doctrine of informed consent evolved, it has become disconnected from its original purpose and turned the fundamental right of bodily integrity into an illusory right.<sup>15</sup>

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9. *See id.* at 495 (dismissing Mrs. Robinson's case because she lacked any legally recognized injury).

10. *See id.* at 491 n.1 (detailing Mrs. Robinson's procreational history by specifically noting that she had three children with her husband and three prior children born out of wedlock).

11. *See infra* Part II (establishing the foundation for the analysis of informed consent for the management of labor pain).

12. *See infra* Part II (detailing each hypothetical assumption and the data that supports each assumption. A hypothetical situation is used because, as this Comment will show, the injury requirement leaves many potential plaintiffs without a cause of action and has thus limited case law).

13. *See infra* Part III (analyzing these particular informed consent statutes because New York State uses the physician-centered standard, Washington State uses the patient-centered standard, and Wisconsin uses a hybrid approach that blends both standards).

14. *See infra* Part IV (recommending that informed consent statutes be amended to explicitly state that inadequate informed consent is a legally cognizable injury, and courts should apply the doctrine of informational standing to recognize the denial of information as a legally cognizable injury).

15. *See infra* Part V (concluding that informed consent no longer protects bodily integrity).

## II. BACKGROUND

*A. Evolution of Informed Consent*

Beginning with a string of cases in the early 1900s, courts began to recognize physician liability for medical battery when physicians acted without or exceeded the scope of a patient's expressed or implied consent.<sup>16</sup> In 1957, California was the first state to articulate the modern informed consent doctrine as one of medical negligence rather than intentional tort.<sup>17</sup> Subsequently, most states codified or affirmed through case law the physician's duty to require informed consent.<sup>18</sup> The physician's duty, as it evolved, was defined under one of two standards: (1) the reasonable care provider, or (2) the reasonable patient.<sup>19</sup> While the standard will determine how much information is disclosed to the patient, there is general agreement that adequate informed consent disclosures include the purpose of the proposed treatment, its risks and benefits, available alternatives (including risks and benefits of alternative treatments), and the effect of no treatment.<sup>20</sup> Once a patient is properly informed, it is the patient's right to choose among the various alternatives rather than a physician's right to prescribe the "best" treatment, even when that choice may be the more dangerous treatment.<sup>21</sup>

When consent is inadequate rather than nonexistent, such as when a

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16. See W.E. Shipley, Annotation, *Liability of Physician or Surgeon for Extending Operation or Treatment Beyond That Expressly Authorized*, 56 A.L.R.2d 695, 704-05 (1957) (detailing 19th century cases where physicians faced tort liability for battery or trespass after successful operations because the operations were unlawful infringement of patient's right when there was no consent).

17. See *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. Ct. App. 1957) (classifying a physician's decision to withhold material information as a breach of his duty rather than considering patient's rights).

18. See, e.g., *Cobbs v. Grant*, 502 P.2d 1, 7-8 (Cal. 1972) (explaining that some states kept an action for battery in the common law because a treatment lacking any consent is a battery).

19. Compare *Culbertson v. Mernitz*, 602 N.E. 98, 103 (Ind. 1992) (explaining that the reasonably prudent physician standard measures disclosure by physician's judgment because a physician is trained to be prudent but cannot be trained to anticipate what every patient would want to know), with *Cobbs*, 502 P.2d at 10-12 (articulating that the prudent patient standard measures disclosures by a patient's judgment as a necessity for patient autonomy because otherwise all discretion is ceded to the physician).

20. E.g., Anna Karpman, Note & Comment, *Informed Consent: Does the First Amendment Protect a Patient's Right to Choose Alternative Treatment?*, 16 N.Y.L. SCH. J. HUM. RTS. 933, 934 (2000) (describing the consensus of the general categories while noting the level of disclosure remains disputed).

21. See *Bankert v. United States*, 937 F. Supp. 1169, 1173 (D. Md. 1996) (holding that the competent patient's right to select among medically acceptable treatments is absolute). See generally *Kulak v. City of New York*, 88 F.3d 63, 74 (2d Cir. 1996) (discussing that the right to control the course of one's own treatment arises from the individual right to bodily integrity).

patient agrees to a specific procedure, but the physician does not tell the patient a procedure's risks, or all the risks, the failure to obtain informed consent is generally categorized as negligence.<sup>22</sup> Thus, for a cause of action, a plaintiff requires an injury proximately caused by the procedure that is causally connected with the inadequate consent.<sup>23</sup> Under the negligence standard, a patient who received inadequate informed consent will be left with no legal remedy if the medical procedure did not result in a legally recognized injury because the negligence standard derives from the physician's breach of a duty to the patient.<sup>24</sup> This is contrary to its battery origins, which derive from the patient's right to be secure in her person.<sup>25</sup>

*B. Beyond Informed Consent: Informational Standing Recognizes That Denial of Information Can Be an Injury in Its Own Right*

Early English and American law required no injury beyond the violation of a private right to sustain a cause of action.<sup>26</sup> Legal scholars and justices throughout the 1700s and 1800s recognized that a right required an avenue for vindication or it was no right at all.<sup>27</sup> Courts repeatedly found that when a plaintiff's private rights were violated, despite any actual injury, nominal damages redressed the plaintiff sufficiently.<sup>28</sup> This doctrine of standing was reevaluated in the 20th Century with the expansion of government regulations and public rights where courts began requiring an "injury-in-fact" and seemed to abandon the explicit "inquiry into the

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22. See *Cobbs*, 502 P.2d at 8 (discussing Dean Prosser's conclusion that the modern trend is to classify inadequate consent as negligence because that is in alignment with the general classification of medical malpractice as a type of negligence).

23. See *id.* at 11 (explaining the connection between informed consent and the cause of action).

24. See *Marie v. McGreevey*, 314 F.3d 136, 142-43 (3d Cir. 2002) (noting that women who received abortions yet alleged inadequate informed consent did not have a legally recognized injury when abortions were performed competently). *Contra Cruz Aviles v. Bella Vista Hosp., Inc.*, 112 F. Supp. 2d 200, 202 (D.P.R. 2000) (explaining that inadequate informed consent is not consent, therefore it is independent and does not require any additional medical malpractice in diagnosis or treatment).

25. See *Schoendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.").

26. See F. Andrew Hessick, *Standing, Injury in Fact, and Private Rights*, 93 CORNELL L. REV. 275, 279-80 (2008) (detailing the history of standing with regards to private rights).

27. See *id.* at 285-86 (exploring opinions of private rights within that time period to show that in a practical sense a right is defined as the existence of a legal remedy to defend it).

28. See *id.* at 279, 326 (discussing the history of nominal damages and noting the effectiveness of nominal damages in deterring police misconduct).

invasion of legal rights.”<sup>29</sup>

Recently, the “injury-in-fact” requirement has begun to change with the recognition of a new class of injury through informational standing.<sup>30</sup> In *FEC v. Akins*, a group of voters sought to challenge the Federal Election Commission’s (FEC) determination that the American Israel Public Affairs Committee (AIPAC) was not a “political committee.”<sup>31</sup> The plaintiffs brought suit alleging that the FEC decision denied them relevant information to which they were legally entitled under the Federal Election Campaign Act of 1971 (FECA) because the FEC’s determination allowed AIPAC to avoid making informational disclosures.<sup>32</sup> Contrary to the Solicitor General’s argument that the plaintiffs did not suffer an “injury-in-fact,” the Court held that the informational injury suffered here was adequately concrete and specific, and the information directly related to the exercise of a fundamental political right: voting. Thus, *Akins* signals that when Congress creates a right to information, and a person is denied that information, that person may have standing without any further injury.<sup>33</sup>

*C. Maternity Care Is Uniquely Suited for a Test Case Analysis of the Adequacy of Informed Consent Statutes*

*1. Maternity Care: Unique, yet Universal*

Pregnancy serves as a window through which to examine medical care and is an excellent platform for the analysis of a legal concept—*informed consent*—that applies to all forms of medical care. Unlike many medical conditions, pregnancy is a predictable condition: for most women, pregnancy will culminate in labor and then birth after a gestation period of 38-42 weeks.<sup>34</sup> With no medical intervention, pregnancy culminates in a

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29. See Jonathan E. Wells, Comment, *Shouldn't Standing Be Closer to the Heart of Congressional Intent?*, 49 EMORY L.J. 1359, 1365-66 (2000) (explaining the recent history of standing and criticizing how this judicial invention abandoned previous private right precedent).

30. See Kimberly N. Brown, *What's Left Standing? FECA Citizen Suits and the Battle for Judicial Review*, 55 U. KAN. L. REV. 677, 689 (2007) (discussing the informational standing doctrine developed in *FEC v. Akins*, 524 U.S. 11 (1998), as a novel method for expanding standing to any statutorily-identified group entitled to the information specified in the statute).

31. See *Akins*, 524 U.S. at 16-18 (explaining that by ruling AIPAC was not a political committee, the FEC shielded AIPAC from disclosure requirements because only political committees must meet the FECA disclosure requirements at issue).

32. See *id.* at 20 (noting that plaintiffs were simply citizens, not members of AIPAC; however, Congress explicitly gave all citizens standing in the language of FECA).

33. See Cass R. Sunstein, *Informational Regulation and Informational Standing: Akins and Beyond*, 147 U. PA. L. REV. 613, 663-65 (1999) (exploring the application of prudential requirements to informational standing).

34. See generally JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT



birth that both mother and baby survive 99 out of 100 times.<sup>35</sup> Although medical intervention is sometimes necessary, the predictability of the outcome without intervention allows medical intervention to be evaluated more readily with pregnancy than with other medical conditions.<sup>36</sup> Again, in contrast to medical conditions that develop rapidly and do not grant sufficient time to analyze patient-physician interactions, maternity care serves as an optimal lens through which to examine patient-provider interactions because pregnancy develops over several months and the general standard of care involves many provider visits.<sup>37</sup> Finally, while most people will not experience most medical conditions, the universality of birth is compelling: everyone begins life through birth, and the United States spends \$86 billion each year on hospitalization related to pregnancy and childbirth.<sup>38</sup>

## 2. Test Case Hypothetical

Anecdotal and statistical evidence indicates that America's maternity care system often fails to meet legal standards of informed consent and that the majority of women are left without legal remedy.<sup>39</sup> Consequentially, this area has not been fully developed through case law, and this Comment will use Ashley Typical, a hypothetical patient, who is in good health at the time of conception and is low-risk and healthy through her pregnancy, as the test case patient based predominantly on the most common maternity care experiences.

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CHILDBIRTH AND MODERN MATERNITY CARE 11 (2007) (explaining that the due date, a median within a normal range, is calculated by adding 280 days to the first day of the woman's last menstrual period).

35. See Irvine Loudin, *Maternal Mortality in the Past and Its Relevance to Developing Countries Today*, 72 AM. J. CLIN. NUTR. 241S, 242S (2000) (detailing the historical rates of maternal mortality from the 1850s to 2000).

36. See *id.* at 244S, 245S (explaining how causes of maternal mortality have varied with societal changes).

37. See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PRENATAL CARE: FREQUENTLY ASKED QUESTIONS 1-2 (2009) [hereinafter HHS FAQ], available at <http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.pdf> (defining prenatal care and detailing the recommended appointment schedule).

38. See AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 1 (2010) [hereinafter DEADLY DELIVERY], available at <http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf> (discussing the economic and social costs of birth).

39. See EUGENE R. DECLERCQ, CHILDBIRTH CONNECTIONS, LISTENING TO MOTHERS II: REPORT OF THE SECOND NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES 72-73 (2006) [hereinafter LISTENING SURVEY], available at <http://www.childbirthconnection.org/listeningtomothers/> (analyzing a national survey of American women, who revealed anecdotal indignities, overall lack of choices, and significant knowledge gaps regarding the risks of the treatments that they had received).

Ms. Typical wanted to be pregnant.<sup>40</sup> She first met her physician, Dr. OB, during her first prenatal appointment when she was nine weeks pregnant.<sup>41</sup> She met with Dr. OB during thirteen prenatal appointments.<sup>42</sup> During one of her appointments, Ms. Typical expressed concern and fear about labor pain, and Dr. OB assured her that anesthesiologists at Hospital General are available 24/7, and she could have an epidural whenever she needed one.<sup>43</sup> For clarity and simplicity, it is assumed that Ms. Typical asked no more questions regarding labor pain, and Dr. OB volunteered no additional information.

During her fortieth week of pregnancy, labor began for Ms. Typical.<sup>44</sup> She proceeded to Hospital General, where she had planned to give birth.<sup>45</sup> Ms. Typical experienced pain in labor that intensified as her labor progressed.<sup>46</sup> Upon her arrival at Hospital General, Ms. Typical's freedom of movement was restricted; she was attached to an Electronic Fetal Monitor and an IV.<sup>47</sup> She did not use the shower for pain relief.<sup>48</sup> Ms. Typical labored in her labor and delivery room with her husband, but she did not have a doula.<sup>49</sup> A registered nurse (RN) monitored and periodically checked on Ms. Typical, but the RN at no time offered comfort measures to help Ms. Typical labor.<sup>50</sup>

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40. *See id.* at 18 (reporting that the majority of participants (57%) wanted to be pregnant).

41. *See id.* at 20 (reporting that most women had their first prenatal appointment during the ninth week of pregnancy).

42. *See id.* at 21 (reporting that 73% of women saw the same provider each time and 79% of women had an obstetrician-gynecologist as their primary caregiver); *see also* HHS FAQ, *supra* note 37, at 3-4 (detailing the recommended standard of care, which involves many prenatal appointments).

43. *See* BLOCK, *supra* note 34, at 164 (describing the climbing epidural rate that exceeds 99% at some hospitals and the decreasing availability of pain management options in labor).

44. *See id.* at 11 (detailing the median gestation is forty weeks).

45. *See id.* at xx (noting that in the United States, 99% of women give birth in a hospital).

46. *See* INA MAY GASKIN, BIRTH MATTERS 38-39 (2011) (refuting the assumptions that labor pain is pointless and inevitable and explaining that pain is not analogous to suffering and vice versa).

47. *See, e.g.*, BLOCK, *supra* note 34, at xix (describing the typical labor experience as involving up to 16 different tubes, drugs, or attachments restraining the laboring patient).

48. *See* LISTENING SURVEY, *supra* note 39, at 32 (noting that while only 4% of women used the shower for pain relief, of those that did, the majority found it at least "somewhat helpful" and 33% found it "very helpful").

49. *See id.* at 30 (reporting that 82% of women labored with a husband or partner for support, but only 3% used a doula, the popular name for a labor companion, typically a woman, who is trained to provide non-medical support to the laboring woman).

50. *Cf.* BLOCK, *supra* note 34, at 15 (discussing how professional pressures on nurses increase when technology is valued more than people).

When Dr. OB checked on her, Ms. Typical described her pain and asked for help managing it.<sup>51</sup> Dr. OB said he could call the anesthesiologist to arrange an epidural.<sup>52</sup> Ms. Typical met with the anesthesiologist who explained how the procedure would go and gave her an informed consent form filled with standard language regarding risks.<sup>53</sup> She signed it and was given the epidural.<sup>54</sup>

### 3. Test Case Statutes

Ms. Typical's situation will be analyzed under three state statutes: New York, Washington, and Wisconsin. New York codified informed consent under "the reasonable medical practitioner" standard.<sup>55</sup> Washington uses the "reasonably prudent patient" (RPP) standard.<sup>56</sup> Wisconsin is a hybrid of the two standards because facially the statute is a "reasonably well-qualified physician" standard, but as applied, Wisconsin courts consider it a "reasonably prudent patient" standard.<sup>57</sup>

#### *i. New York State*

For a cause of action under New York State's informed consent statute, a plaintiff must establish that: (1) the foreseeable risks and benefits of the proposed treatment and any alternatives that a "reasonable medical . . . practitioner under similar circumstance would have disclosed" were not disclosed; (2) a "reasonably prudent patient" would have declined the treatment if proper disclosure occurred; and (3) the lack of informed consent proximately caused a legally recognized injury.<sup>58</sup> Even if a plaintiff is able to show the first prong, the objective test of the second prong is difficult to satisfy because the fact finder will weigh the risk of having the procedure versus the risk of forgoing it, without considering

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51. See *id.* at 174-75 (discussing a laboring woman's need to manage or work through labor pain).

52. See LISTENING SURVEY, *supra* note 39, at 32 (reporting that the majority of surveyed mothers used epidural or spinal analgesia).

53. See GASKIN, *supra* note 46, at 24 (describing various side effects of the epidural procedure).

54. See LISTENING SURVEY, *supra* note 39, at 32 (reporting that 76% of surveyed mothers used epidural or spinal analgesia).

55. See N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2011) (articulating a three prong test to sustain a cause of action).

56. See WASH. REV. CODE § 7.70.050 (2011) (articulating a four prong test a RPP must prove).

57. See WIS. STAT. § 448.30 (2011) (articulating an incredibly broad duty of disclosure); see also *Schreiber v. Physicians Ins. Co. of Wis.*, 588 N.W.2d 26, 31 (Wis. 1999) (articulating the test for disclosure as what the RPP would require to make an intelligent decision).

58. See N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2011) (describing the limitations on medical malpractice action for informed consent).

remote risks.<sup>59</sup> In *Avakian v. United States*, the district court held that the “reasonably prudent patient” would find that when the risks of a myelogram (a diagnostic procedure), not including the remote risk of paralysis, were weighed against the patient’s chronic back pain, which could not be properly diagnosed and treated without the myelogram, the RPP would consent to a myelogram because the risks of forgoing treatment outweigh the procedure’s risks.<sup>60</sup> Mrs. Avakian’s actual preference or risk tolerance was irrelevant because the standard used is an objective one.<sup>61</sup>

In addition to establishing the first two prongs, there must be an injury beyond violating one’s right to bodily integrity for an informed consent claim to proceed.<sup>62</sup> While New York courts have found a sufficient injury where a patient’s child is injured during birth, as occurred in *Cerny v. Williams*, the courts have not recognized a blood transfusion to be a sufficient injury even when it is against the person’s faith, as was the case in *DiGeronimo v. Fuchs*.<sup>63</sup>

#### ii. Washington State

Washington’s informed consent statute requires four elements to support an informed consent claim: (1) that the health care provider failed to disclose a “material fact;” (2) that the patient was either unaware or not fully informed of such “material fact;” (3) that without such “material fact,” a “reasonably prudent patient under similar circumstances would not have consent[ed] to the procedure;” and (4) that the treatment proximately caused the patient to suffer an injury.<sup>64</sup>

In addition to this statute, Washington retains the common law action for

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59. See *Avakian v. United States*, 739 F. Supp. 724, 739 (N.D.N.Y. 1990) (holding that the RPP would not consider remote risks, even serious ones such as paralysis).

60. See *id.* at 731-32 (holding that the RPP would weigh the risks of forgoing the myelogram against the ordinary risks of the procedure, which included nausea, seizures, and temporary disorientation).

61. See *id.* at 731 (omitting any discussion of plaintiff’s personal risk tolerance or valuation of treatment).

62. See *DiGeronimo v. Fuchs*, 927 N.Y.S.2d 904, 908 (Sup. Ct. 2011) (holding that a blood transfusion to a devout Jehovah’s Witness does not constitute a legally recognized injury because transfusion was lifesaving and New York does not have a wrongful life statute). But see *Cerny v. Williams*, 822 N.Y.S.2d 548, 552-53 (App. Div. 2006) (holding that birth defects that occurred because a Cesarean section was delayed for unsuccessful induction would satisfy proximate injury if the plaintiff can establish that the Cesarean was not disclosed as an alternative).

63. See *Cerny*, 822 N.Y.S.2d at 552 (finding that the injuries to a patient’s child due to the mother’s medical treatment during labor would satisfy proximate injury). But see *DiGeronimo*, 927 N.Y.S.2d at 907 (holding that without physical harm or sufficient emotional distress, there is no injury).

64. See WASH. REV. CODE § 7.70.050 (2011) (describing the elements of proof required for an informed consent failure).

medical battery where no consent is obtained.<sup>65</sup> Courts have held that medical battery protects an individual's right to privacy and bodily integrity, whereas informed consent protects a patient's autonomy through adequate information.<sup>66</sup> As demonstrated in *Degel v. Buty*, the court rejected the plaintiff's claim that divorcing bodily integrity from informed consent and applying an objective standard violates a patient's due process rights.<sup>67</sup> Under Washington law, if a patient consents to a procedure, but would not have consented to the procedure had she known of an alternative that should have been disclosed, she will be without a legal remedy because: (1) if she fails the third prong (the RPP would have consented), she has no informed consent case; and (2) by her consent, though uninformed, she has foreclosed a battery action.<sup>68</sup> The statute's third prong is a factually driven inquiry, and as the court stated in *Bundrick v. Stewart*, even undisputed subjective consent prior to a procedure will not be dispositive for the objective test.<sup>69</sup> The fourth prong is satisfied when a patient is injured by a risk he was unaware of or if he would have been uninjured had he chosen an undisclosed alternative; this can be determined by the fact-finder or through the parties' stipulation.<sup>70</sup>

### iii. Wisconsin State

Wisconsin's informed consent statute is uncommonly broad and requires that physicians describe the risks, benefits, and all alternative treatments.<sup>71</sup> Wisconsin courts have held that disclosure requirements are necessary because patients need information in order to exercise intelligent treatment decisions.<sup>72</sup> Furthermore, a competent patient has the absolute right to

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65. See *Bundrick v. Stewart*, 114 P.3d 1204, 1208 (Wash. Ct. App. 2005) (discussing legislative history and statutory language to determine that enactment of an informed consent statute did not supersede a cause of action for medical battery).

66. See, e.g., *id.* (distinguishing between the purposes of battery and informed consent to establish why battery requires no injury).

67. See *Degel v. Buty*, 29 P.3d 768, 769-71 (Wash. Ct. App. 2001) (separating patient autonomy from bodily integrity because they are different rights that require different protections).

68. See *id.* (holding that because the standard for recovery and patient choice do not have a causal relationship, an objective standard for an informed consent action that ignores what a patient subjectively would have chosen may deny recovery, but does not deny her the right to determine her own care).

69. See *id.* (holding that the objective standard was not met and a reasonably prudent patient would have consented to the procedure despite conflicting expert testimony).

70. See *Bundrick*, 114 P.3d at 1208 (further articulating the negligence standard as it differentiates from medical battery because no injury is required under battery).

71. See WIS. STAT. § 448.30 (2011) (articulating the expansive disclosure requirement for treatment alternatives).

72. See, e.g., *Schreiber v. Physicians Ins. Co. of Wisconsin*, 588 N.W.2d 26, 30 (Wis. 1999) (detailing how informed consent is patient-driven because it is a central

choose among viable medical alternatives, even if the alternative is not *per se* recommended.<sup>73</sup>

Wisconsin's informed consent statute provides that a physician may defend his failure to disclose by asserting defenses such as: the information was beyond what a "reasonably well-qualified physician in a similar medical classification would know," the information was so technical that it was beyond the patient's comprehension, the information was already apparent or known to the patient, or there was an "extremely remote possibilit[y] that might [have] falsely or detrimentally alarm[ed] the patient."<sup>74</sup> The Wisconsin Supreme Court stated in *Brown v. Dibbel* that though the list of defenses within the statute is not exhaustive, courts should be cautious when instructing juries on defenses not expressly provided in the informed consent statute.<sup>75</sup> If the physician fails to disclose information and cannot assert a defense, courts apply a RPP test to determine whether the patient would have consented to the procedure if the information had been disclosed, thus creating a cause of action.<sup>76</sup> Because Wisconsin courts view informed consent as a process, rather than an event, which may evolve with new medical or legal developments, patients can revoke consent.<sup>77</sup> Thus, if the factual record shows the patient revoked consent, Wisconsin courts do not apply the objective test.<sup>78</sup> Such was the case in *Schreiber v. Physicians Ins. Co.*, where the court held that the patient's unequivocal revocation of consent should have triggered a new informed consent discussion.<sup>79</sup>

Furthermore, Wisconsin courts have stressed that a patient does not have an affirmative duty to determine the completeness, accuracy, or truthfulness of the physician's disclosures because of the special

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method to ensure the fundamental right of bodily integrity).

73. *See id.* at 26, 29-32 (holding that a patient had an absolute right to choose a Cesarean section over an induction because both were viable medical options).

74. *See* WIS. STAT. § 448.30 (listing defenses to failing to disclose treatment information; other defenses that are not applicable for this hypothetical include emergency situations and incapable patients).

75. *See Brown v. Dibbell*, 595 N.W.2d 358, 372 (Wis. 1999) (explaining that deviating from the specified defenses should only be considered when evidence of a specific reason for withholding information has been offered by the defendant).

76. *See id.* at 366 (explaining that Wisconsin follows the majority of jurisdictions by applying the objective test to prevent plaintiff's hindsight from unfairly affecting litigation).

77. *See Schreiber*, 588 N.W.2d at 32-33 (declining to define informed consent as a singular event because, as circumstances change, the risks may change and/or the patient's tolerance of risk may change).

78. *See id.* at 34 (stating that applying the objective test after clear revocation could lead to "absurd results").

79. *See id.* at 34-35 (holding that once the patient requested a Cesarean section, the physician was required to revisit the risks and benefits of all viable medical options).

relationship of trust that patients have with their doctors.<sup>80</sup> Nonetheless, Wisconsin's patient-centered informed consent statute is still a negligence statute, requiring an injury to sustain a cause of action.<sup>81</sup> Unlike New York, under Wisconsin's informed consent statute, the injury may be a possible complication that arises out of a properly performed procedure; such as in *Brown*, when the plaintiff suffered discomfort and disfigurement arising from a properly performed double mastectomy.<sup>82</sup>

### III. ANALYSIS

The disclosure of alternative procedures is an important aspect of informed consent because not having this type of information effectively restricts a patient's ability to make intelligent choices about her own care.<sup>83</sup> Ms. Typical sought pain management, and she was offered only one treatment, an epidural, and was deemed to have "chosen" it.<sup>84</sup> Even assuming Ms. Typical received adequate information regarding the risks of receiving an epidural through the standard informed consent form, Dr. OB never disclosed to Ms. Typical any alternative treatments for her labor pain at any point in her treatment.<sup>85</sup>

#### *A. In New York, Ms. Typical Does Not Have a Cause of Action Because Failure to Discuss Pain Management Alternatives Falls Within New York's Limitations on Medical Malpractice Action Based on Lack of Informed Consent and Bars a Cause of Action.*

Even though Ms. Typical chose the only treatment option Dr. OB presented to her at any time during his eight-month treatment of her pregnancy, she will not be able to satisfy any of three prongs of New York's informed consent statute necessary to establish a cause of action.<sup>86</sup>

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80. See *Brown*, 595 N.W.2d at 362 (declining to hold that the patient was guilty of contributory negligence for failing to ask additional questions because it is not the patient's job to cure the physician's failure to disclose).

81. See *id.* at 366 (explaining that the informed consent statute codifies the physicians' duty, and when plaintiffs' damages resulted from physicians' breach of the duty to provide informed consent, they are liable for those damages).

82. See *id.* at 364-65 (holding that once the fact-finder finds that a reasonable patient would have refused the procedure, any harm that results from the procedure will be sufficient to sustain a negligence action under informed consent).

83. See, e.g., *Cobbs v. Grant*, 502 P.2d 1, 10-12 (Cal. 1972) (holding reasonable disclosure of alternatives is a vital aspect of the physician's duty).

84. See *supra* Part II.C.2 (describing the test patient's situation).

85. See *supra* Part II.C.2 (noting that initially Ms. Typical described her concerns about labor pain and later asked for assistance managing pain, and in both instances Dr. OB offered an epidural as her "cure" without any discussion of alternatives).

86. See N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2011) (articulating a three-prong test for a reasonably prudent medical practitioner).

*1. Ms. Typical Is Unlikely to Satisfy the First Prong of the Informed Consent Statute Because a Reasonable Medical Practitioner Under Similar Circumstances Probably Would Not Have Disclosed Any Other Pain Management Alternatives.*

Under the first prong, Ms. Typical will have to establish that Dr. OB deviated from an accepted community standard of medical practice when he failed to disclose other pain management alternatives.<sup>87</sup> Deviation from accepted medical practice is a factually driven inquiry that relies heavily on expert testimony but can still be decided as a matter of law or stipulated to by the parties.<sup>88</sup>

Because normative practices often define standards of practice, it is important to remember that epidural rates are extraordinarily high compared to any other form of pain management technique.<sup>89</sup> Given that some forms of pain management are considered as effective as epidurals at managing pain, yet lack some of the serious side effects, it may be inferred that many women are not fully aware of the availability and effectiveness of other pain management alternatives when they choose epidurals for pain management.<sup>90</sup> Conflicting testimony of medical experts that a doctor deviated from accepted medical practice by not describing pain management alternatives is not sufficient to create a question of fact as to whether the patient acted under informed consent.<sup>91</sup> Even if Ms. Typical has an expert testify that he or she would have disclosed alternate pain management options, a court, as occurred in *Cerny*, may be unconvinced by the expert's testimony when it considers the sheer magnitude of epidural usage in labor as compared to other methods.<sup>92</sup> Therefore, the court is likely to rule as a matter of law that Dr. OB did not deviate from the

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87. See, e.g., *DiGeronimo v. Fuchs*, 927 N.Y.S.2d 904, 907 (Sup. Ct. 2011) (detailing that under a medical negligence standard the physician's duty is defined by complying with community standards).

88. See *Cerny v. Williams*, 822 N.Y.S.2d 548, 555 (App. Div. 2006) (allowing parties to stipulate that failing to undertake the curative step of a Cesarean section was not in accordance with the doctor's standard of care).

89. See LISTENING SURVEY, *supra* note 39, at 32 (reporting that epidural use far exceeds other pain management techniques).

90. See GASKIN, *supra* note 46, at 38-40, 53-54 (exploring women's attitudes about pain in labor and detailing their lack of knowledge of other effective pain relief methods such as doulas, comfort measures, or water (bath or shower)).

91. See *id.* at 38-39 (noting that in *Cerny*, even though the plaintiffs' medical expert testified that a forty-three minute delay to begin a Cesarean section following a failed induction was a departure from accepted medical practice, the court found the expert's testimony unconvincing and held as a matter of law that there was no departure from standard medical practice).

92. See *Cerny*, 822 N.Y.S.2d at 553 (holding that as a matter of law, a forty-three minute delay from the time that the Pitocin was discontinued until the delivery was not inconsistent with acceptable standards of care despite conflicting expert testimony).



standard of practice.<sup>93</sup> Again, because disclosure is measured normatively, it is likely that Dr. OB could establish as a matter of fact, even if not as a matter of law, that he did not deviate from the standard of practice by only describing, then offering, the epidural as Ms. Typical's only treatment option for her pain.<sup>94</sup>

*2. Ms. Typical Is Unlikely to Satisfy the Second Prong of the Informed Consent Statute Because a Reasonably Prudent Patient Would Probably Consent to an Epidural for Pain Management.*

New York's RPP calculates treatment decisions by considering the risks of the treatment compared to the risks of refusing the treatment without considering remote risks.<sup>95</sup> In *Avakian*, the court found that the RPP would have consented to a myelogram because the risk of forgoing the myelogram outweighed the risks of the procedure.<sup>96</sup> The court also held that the RPP would not consider the remote possibility of paralysis, even though there were at least two reported cases of irreversible neurological complications.<sup>97</sup> Further, consenting to a myelogram did not guarantee that Mrs. Avakian would be cured of her pain, and the facts that Mrs. Avakian had periodically suffered back pain throughout her life, was an active mother of a small child, and contributed to family finances by working outside the home did not enter into the RPP calculus.<sup>98</sup>

Just as the myelogram may have diagnosed Mrs. Avakian's condition but did not guarantee relief, an epidural may grant a majority of women relief but will be ineffective for a minority of laboring mothers.<sup>99</sup> While labor pain is temporary rather than chronic, and the procedure is different, the risk factors of epidurals are similar to myelograms: laboring women may experience nausea; headaches; itching; incomplete pain relief; a dangerous

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93. *See id.* (holding that an expert's testimony does not necessarily create an issue of fact).

94. *See id.* at 550-52 (indicating that whether the defendant committed medical negligence and failed to obtain informed consent before inducing plaintiff was an issue of fact).

95. *See Avakian v. United States*, 739 F. Supp. 724, 731 (N.D.N.Y. 1990) (dismissing even serious risks such as death because the RPP does not consider such remote risks).

96. *See id.* at 731-32 (holding that the risks of the myelogram were low and worth taking because the myelogram could have proven that Avakian had a herniated disc, which, if properly treated, may have alleviated her intermittent back pain).

97. *See id.* at 731 (noting that at the time the procedure was performed only two known cases of paralysis resulted from the approximately 2.5 million myelograms that had been performed).

98. *See id.* at 726-28 (concluding that Mrs. Avakian's decision to seek treatment was dispositive of her risk valuation).

99. *See LISTENING SURVEY*, *supra* note 39, at 32 (reporting that 9% of surveyed women found that epidurals were not at all helpful or not very helpful in managing labor pain, and an additional 10% of women surveyed found it only somewhat helpful).

drop in blood pressure experienced by 20-30% of women; a fever which will develop in 15-20% of women; blocking of natural endorphins; increased risk of pelvic, pelvic floor, and vaginal injury; and increased risk of Cesarean section.<sup>100</sup> Though epidural patients face increased risk of paralysis compared to myelogram patients, the risk of paralysis or death, though possible, is remote; therefore, in New York, the RPP would disregard those risks.<sup>101</sup> Overall, a New York court is likely to find that a myelogram is similar enough to an epidural for the court to find that the RPP would probably consent to an epidural.<sup>102</sup> Furthermore, an epidural's popularity is likely to be a dispositive factor.<sup>103</sup> Hence, it seems likely that regardless of whether Ms. Typical would have consented to an epidural if she had other options, in New York, the RPP would have consented.

*3. Ms. Typical Is Unlikely to Satisfy the Third Prong of the Informed Consent Statute Because Even if Ms. Typical Is Injured as a Result of Receiving the Epidural, the Lack of Informed Consent Would Not Be the Proximate Cause of Her Injuries.*

Finally, unless Ms. Typical has a separate cause of action for a negligently administered epidural, she will not have an injury sufficient to support the damage necessary for a lack of informed consent cause of action.<sup>104</sup> As the court held in *Avakian*, the mere occurrence of a possible risk does not satisfy the proximate injury element if the physician performs the procedure properly.<sup>105</sup> Conversely, the court in *Cerny v. Williams* found that if the mother was not informed about the risks of induction and the induction was not performed in accordance with the standard of care, then any injuries caused to the child by delaying a Cesarean section would

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100. See BLOCK, *supra* note 34, at 172, 174 (describing the procedure of inserting a needle into the epidural space surrounding the spinal cord, then replacing the needle with a catheter through which an anesthetic and opiate cocktail “bathes” the spinal nerves and numbs all or most feeling below the navel).

101. See DEADLY DELIVERY, *supra* note 38, at 77 (describing the risk of infection that results from inserting a needle into the spinal space and that can result in meningitis and death).

102. See BLOCK, *supra* note 34, at 171 (detailing that though epidurals have many side effects and are associated with longer labors, increased likelihood of vaginal tears or episiotomies, and increased rates of Cesarean sections, the remote risks of death or paralysis are very rare, much like the myelogram procedure).

103. See LISTENING SURVEY, *supra* note 39, at 32 (stating that more than 75% of women surveyed used an epidural for pain management).

104. See *Avakian v. United States*, 739 F. Supp. 724, 731 (N.D.N.Y. 1990) (explaining that injuries which occur as part of a properly performed medical procedure are not sufficient to constitute proximate cause for policy reasons).

105. See *id.* at 732-33 (holding that because her doctor complied with the necessary standard of care, Mrs. Avakian's injuries would not support a malpractice claim as it would be unreasonable and impractical to hold a doctor liable for a procedure that did not yield a good result when he has exercised the necessary skill).

have been a proximate cause; however, in that instance, Mrs. Cerny would have had a separate cause of action for a medical malpractice for an improperly performed induction.<sup>106</sup> Furthermore, intangible injuries, such as violating one's bodily integrity by giving a blood transfusion against one's wishes and/or religious beliefs, will not suffice as an injury.<sup>107</sup>

Thus, even in the remote and unlikely scenario that Ms. Typical were to die or suffer paralysis as a result of her epidural, so long as the epidural was properly administered, she would not have an injury under the third prong of New York's statute.<sup>108</sup> If Ms. Typical receives a negligently administered epidural that causes her harm, such as an infection, paralysis, or death, then those injuries would likely satisfy the third prong of the statute, but she would also have a separate claim for malpractice.<sup>109</sup> If Ms. Typical is offended or distressed because she feels coerced into her choice like Mrs. DiGeronimo, who suffered emotional distress from having another person's blood transfused into her body against her religious beliefs even though this was not a sufficient injury to sustain a cause of action, Ms. Typical's distress will certainly fail to be an injury.<sup>110</sup>

To sustain a malpractice action based on lack of informed consent, a plaintiff must meet all three elements of New York's informed consent statute.<sup>111</sup> Since Ms. Typical is unlikely to meet all three, she cannot sustain an action based on inadequate informed consent in New York State.

*B. In Washington State, Ms. Typical Likely Does Not Have a Cause of Action Because Failure to Discuss Pain Management Alternatives Probably Will Not Meet the Necessary Elements of Proof to Establish That Dr. OB Failed to Secure Informed Consent.*

Washington State requires four elements of proof to establish a failure to secure informed consent: (1) the medical provider did not disclose to the patient a "material" fact or facts relating to the procedure; (2) the patient

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106. *See* Cerny v. Williams, 822 N.Y.S.2d 548, 552 (App. Div. 2006) (holding that since the Cesarean section was performed without malpractice, any actual injuries suffered would not be legally recognized because some injuries will still naturally arise during properly performed treatment).

107. *See* DiGeronimo v. Fuchs, 927 N.Y.S.2d 904, 907 (Sup. Ct. 2011) (holding that plaintiff did not receive a legally cognizable injury when she was given a lifesaving blood transfusion even though she was a devout Jehovah's Witness).

108. *See id.* (holding that without a departure from good, acceptable medical care there can be no legally recognized injury).

109. *See id.* (determining that a properly performed blood transfusion could not sustain a malpractice case, but a transfusion that transmitted disease, was the wrong blood type, or was delayed would result in a valid case).

110. *See id.* at 908 (defining an injury in a medical malpractice case as causally related to the breach of care).

111. *See* N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2011) (articulating a three prong test based on a reasonably prudent medical practitioner standard).

consented to the procedure with no or inadequate knowledge of said facts; (3) a RPP would not have consented had she known the undisclosed “material facts;” and (4) the procedure proximately caused injury to the patient.<sup>112</sup>

*1. Ms. Typical May Be Able to Establish the First Two Prongs of the Informed Consent Statute Because These Prongs Are Generally Undisputed or Are Questions of Fact for the Jury.*

Courts rarely discuss the first two elements of the statute, as they are factually bound inquiries, and most parties to the litigation will not dispute treatment information as material facts.<sup>113</sup> The parties can, and often do, stipulate to these elements as in *Degel*, where the defendant stipulated that he did not get his patient’s consent before performing the artificial rupturing of her membranes (AROM).<sup>114</sup> When there is dispute over an element, as occurred in *Bundrick*, where the parties disagreed as to whether Mrs. Bundrick consented to the procedure, the evidence is submitted to the jury.<sup>115</sup>

In Ms. Typical’s case, because the Washington courts classify most information that a patient could consider when making a treatment decision a material fact, it seems likely that the court would find pain management alternatives to be material facts.<sup>116</sup> The parties will likely either stipulate to Ms. Typical’s consent, as in *Degel*, or leave it as a question of fact for the factfinder, as the court found in *Bundrick*.<sup>117</sup> Dr. OB never discussed any alternative procedures, and the availability and effectiveness of alternative pain management techniques would likely have been material facts Ms. Typical would have at least considered before consenting to the epidural. Therefore, a Washington court is unlikely to find she was fully informed under the statute. Nonetheless, Ms. Typical’s signed consent form may persuade a jury that she consented even if she did not have the information

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112. See WASH. REV. CODE. § 7.70.050 (2011) (stating that a plaintiff must prove each element of the four-prong test to sustain a claim).

113. See, e.g., *Bundrick v. Steward*, 114 P.3d 1204, 1208-09 (Wash. Ct. App. 2005) (holding as a matter of law that the surgeon’s identity is a material fact).

114. See *Degel v. Buty*, 29 P.3d 768, 769 (Wash. Ct. App. 2001) (describing the defendant’s stipulation that he did not discuss the material risks of the AROM with his patient).

115. See *Bundrick*, 114 P.3d at 1209 (finding that the jury must determine if the plaintiff consented by considering evidence of the plaintiff’s oral claims against her broad written consent).

116. See *id.* at 1208-10 (noting that the resident’s participation in plaintiff’s surgery was a material fact); see also *Degel*, 29 P.3d at 769 (considering the risk of cord prolapse during AROM a material fact).

117. See *Degel*, 29 P.3d at 770 (allowing parties to stipulate that defendant did not seek plaintiff’s consent before performing the procedure); *Bundrick*, 114 P.3d at 1208-10 (sending the consent question to the jury).

required to satisfy the statute.<sup>118</sup>

*2. Ms. Typical Is Unlikely to Establish the Third Prong of the Informed Consent Statute Because a Reasonably Prudent Patient Would Probably Consent to an Epidural for Pain Management.*

Like in New York, Washington courts apply an objective test to determine whether the physician's disclosure satisfies informed consent.<sup>119</sup> However, unlike New York's strict balancing of the risks test, which does not consider remote risks, Washington courts consider the broader circumstances, including remote risks, when determining if a RPP would have consented to the epidural.<sup>120</sup> In *Degel*, the jury found for the defendant, contrary to the plaintiff's assertions and despite conflicting expert testimony that quantified the risk of cord prolapse, a life threatening complication for the fetus when a physician performs AROM when the fetus is high in the pelvis.<sup>121</sup> In *Bundrick*, a jury found the plaintiff's signature on a broad standard informed consent form was more dispositive of the RPP's consent than the plaintiff's oral qualifications limiting the scope of the informed consent form prior to the surgery.<sup>122</sup> Because it is difficult to predict what weight a fact-finder will give different pieces of evidence, the outcome of any inquiry is not certain.<sup>123</sup> Since the majority of laboring women use epidurals as their primary method of pain relief, Ms. Typical will face the same hurdles the plaintiff in *Degel* faced because Ms. Typical is not likely to overcome the burden of proof necessary to show that the RPP would not have consented to an epidural.<sup>124</sup> Like *Bundrick*, Ms. Typical will also have to refute a signed consent form, and it seems unlikely that Ms. Typical will be able to overcome these factors and

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118. See *Degel*, 29 P.3d at 770 (finding that knowledge is a factual inquiry best performed by the fact-finder).

119. See *id.* (explaining that the objective test prevents plaintiffs from stating that they would not have consented had they known the risks before they manifested).

120. See *Bundrick*, 114 P.3d at 1209-10 (holding that it is the jury who must weigh the various circumstances to determine whether a RPP would have consented to the procedure at issue).

121. See *Degel*, 29 P.3d at 769 (noting that defendant admitted to forgoing patient consent for AROM because he believed her consent to induction included AROM).

122. See *Bundrick*, 114 P.3d at 1209 (explaining that the jury found the plaintiff's signed, broad consent to "all medical treatment . . . performed . . . by/or at the direction of the attending physician" was more dispositive of a RPP standard than plaintiff's oral rejection of a resident actually operating with her surgeon rather than simply observing him).

123. See *id.* (finding that although alternate conclusions may be drawn from the same evidence, ultimately the jury makes the final determination on matters of fact).

124. See *Degel*, 29 P.3d at 769 (describing expert testimony that stated the expert had never had a patient decline an AROM after being informed of the risks and finding that persuasive as a matter of law).

prevail on this objective prong.<sup>125</sup>

*3. Unless Ms. Typical Is Injured During the Administration of the Epidural, She Will Not Have a Cause of Action.*

Similar to New York, Washington has classified the lack of informed consent as a type of medical negligence.<sup>126</sup> Washington's causation standard is lower than New York's standard; if an injury occurs that the physician did not disclose and that would not have occurred if the patient had chosen an undisclosed alternative, then the injury satisfies the causal element of the Washington statute.<sup>127</sup> Hence, in *Bundrick*, if the plaintiff could have passed the objective test for the bowel injury she received during the surgery and the additional surgery complications that resulted, without any showing of further negligence beyond the lack of informed consent, she would have sustained a cause of action.<sup>128</sup> Thus, if a properly administered epidural injured Ms. Typical, she will satisfy this final element of proof, but without an injury, Ms. Typical will lack a cause of action.<sup>129</sup>

Nonetheless, because failing just one element of the negligence standard makes it impossible to prove failure to secure informed consent, and Ms. Typical is likely to fail both the objective RPP test and the injury requirement, she is unlikely to have a cause of action under the Washington standard.<sup>130</sup>

*C. Under Wisconsin Law, Failure to Discuss Pain Management Alternatives Likely Violates Dr. OB's Statutory Obligation to Provide Information, but Ms. Typical Probably Will Not Have a Cause of Action Unless She Is Injured by the Administration of the Epidural.*

On its face, Wisconsin's informed consent statute requires the disclosure of all the risks, benefits, and alternative treatments and specifies a few

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125. See *Bundrick*, 114 P.3d at 1209 (describing the weaknesses of standard consent forms but upholding the jury's finding that the signed consent form was dispositive of consent).

126. See *id.* at 1207-08 (determining that negligent conduct without proximate injury does not satisfy a negligence standard).

127. See *id.* (discussing proximate injury in comparison to battery cause of action where no injury is required).

128. See *id.* (stating that injuries which result from medical malpractice have a separate cause of action, so it would be absurd to require malpractice to meet the injury prong).

129. See *id.* (holding that whether the sutures that led to the complications were improperly done or not was irrelevant to determining injury if the operation itself lacked consent).

130. See WASH. REV. CODE § 7.70.050 (2011) (stating that if the plaintiff fails on any element, then the claim fails).

defenses, such as that the “information is beyond what a reasonably well-qualified physician in a similar medical classification would know.”<sup>131</sup> Wisconsin courts have created an additional test for informed consent by consistently holding that the only information required is that which a RPP would need to make an intelligent treatment decision.<sup>132</sup> The failure to disclose such required information is a negligent act in violation of the statute; but, to sustain a negligence cause of action for inadequate informed consent, the plaintiff must have an injury.<sup>133</sup>

*1. Available Pain Management Alternatives Are Likely to Be Alternative Modes of Treatment That Would Require Disclosure.*

All viable medical options that a “reasonably well-qualified physician would know” must be disclosed to the patient, even if the options are not considered medically indicated.<sup>134</sup> Because the court in *Schreiber* clearly articulated that Wisconsin courts find informed consent is a process rather than a singular event, a court could hold that Ms. Typical’s interactions with Dr. OB from the prenatal appointments onward were opportunities for Dr. OB to meet his statutory obligations.<sup>135</sup> While comfort measures (such as point pressure or massage) or water therapy (such as bathtubs or showers) may not offer the same pain management effectiveness as epidurals do for the majority of laboring women, some laboring women have found these pain management techniques effective, and these techniques are all much less invasive and have none of the serious risks associated with epidurals.<sup>136</sup> Therefore, just as the patient in *Brown* could compare a double mastectomy with periodic mammograms or a needle biopsy even though the procedures had different risks and effectiveness in identifying or preventing breast cancer, a court is likely to find that Ms. Typical would want the ability to consider various pain management alternatives with different risks and degrees of effectiveness in alleviating

131. See WIS. STAT. § 448.30 (2011) (articulating an expansive disclosure requirement with limited defenses for justifying disclosure failures such as emergency situations).

132. See *Brown v. Dibbell*, 595 N.W.2d 358, 366 (Wis. 1999) (determining the doctor’s duty to provide information from the patient’s need because the purpose of informed consent is patient autonomy).

133. See *id.* at 365 (holding that known, possible complications of a properly executed procedure will suffice as an injury to sustain a negligence cause of action).

134. See WIS. STAT. § 448.30 (articulating an expansive disclosure requirement).

135. See *Schreiber v. Physicians Ins. Co. of Wis.*, 588 N.W.2d 26, 31 (Wis. 1999) (holding that while, at some point in most procedures, a patient may no longer be able to withdraw consent for practical reasons there is no need to arbitrarily create a moment of informed consent at a particular point in the treatment).

136. See BLOCK, *supra* note 34, at 174-75 (comparing epidural effectiveness and possible side effects with other pain relief methods to illustrate that epidurals are excellent tools when necessary but should be applied cautiously).

her pain before making her decision.<sup>137</sup> Furthermore, given that pain management techniques such as comfort measures, water therapy, doulas, and encouraging freedom of movement have been sufficiently studied to be classified as evidence-based alternatives, it is unlikely that a Wisconsin court would accept Dr. OB's possible defense that a "reasonably well-qualified" obstetrician would be unfamiliar with these alternatives.<sup>138</sup> Whether Dr. OB would find them medically indicated is irrelevant since the court in *Schreiber* held that the doctor's opinion of the treatment option is immaterial.<sup>139</sup> Thus, Ms. Typical would likely be able to establish that information regarding alternative pain management treatments is the type of information that Wisconsin's informed consent statute requires.

*2. Even Though a Reasonably Prudent Patient Would Likely Consider Knowledge of Other Pain Management Techniques Required to Make an Informed Decision, a Reasonably Prudent Patient May Still Choose an Epidural to Treat Labor Pain.*

Unlike the objective standards previously analyzed under the New York and Washington laws, Wisconsin courts use the RPP standard to first determine what information must be disclosed, rather than using it solely as a predictor for what treatment the RPP would choose.<sup>140</sup> Another unique aspect of Wisconsin law is that if a patient unequivocally states her subjective treatment decision prior to the procedure or injury, then Wisconsin courts do not consider whether the RPP would have made a different treatment decision.<sup>141</sup> In *Brown*, the RPP would have required knowledge of less invasive alternatives and an adequate explanation of the procedure's risks before the RPP could make an intelligent decision as to whether she should undergo a double mastectomy.<sup>142</sup> After the *Brown* court determined that the RPP would require that information, the jury

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137. See *Brown*, 595 N.W.2d at 371-73 (weighing the probability of contracting breast cancer against the effectiveness and risks of various treatment options).

138. See BLOCK, *supra* note 34, at 36-38 (examining common practices in maternity care and evaluating their effectiveness to find that many routine practices such as supine pushing are classified as "ineffective or harmful" while many untraditional methods such as ensuring freedom of movement are "beneficial").

139. See *Schreiber*, 588 N.W.2d at 30-31 (holding that a patient has the right to choose any of the medically-viable treatments without being limited by a physician's recommendation).

140. See *Brown*, 595 N.W.2d at 366 (emphasizing that patient autonomy requires adequate information).

141. See *Schreiber*, 588 N.W.2d at 34 (explaining that the objective test prevents a patient's decisions from being affected by hindsight, but when a patient's decision is clearly articulated prior to the procedure, the objective test should not be applied because it may lead to "absurd results").

142. See *Brown*, 595 N.W.2d at 364 (determining that without adequate information the choice becomes illusory).



found that, based on all the statutorily required treatment information of risks, benefits, and alternatives, a RPP would not have consented to a double mastectomy.<sup>143</sup> In *Schreiber*, the court held that a RPP would have wanted to have additional information regarding the risks and benefits of continuing the Vaginal Birth After Cesarean (VBAC) compared with a Cesarean section.<sup>144</sup> Furthermore, because the patient in *Schreiber* clearly articulated that she did not want to proceed with the VBAC and, instead, wanted her physician to perform the Cesarean section, the court held it was not necessary to determine whether a RPP would have continued to the VBAC or opted for a Cesarean section because the patient's undisputed wishes refuted any claim of hindsight.<sup>145</sup>

Here, Ms. Typical should be able to establish that a RPP would need to know pain management alternatives to make an informed decision regarding treatment options because, by offering her only one pain management option, Dr. OB circumscribed Ms. Typical's decision-making ability.<sup>146</sup> Wisconsin's clear emphasis on patient autonomy strongly supports the inference that a RPP requires knowledge regarding treatment alternatives.<sup>147</sup> However, because epidural rates are so high in America, and the most serious risks—paralysis and death—are very remote, it may be difficult to establish that a RPP would not have consented to an epidural.<sup>148</sup> Nonetheless, in light of rising maternal mortality rates, the United States' poor maternal health care rating in comparison to other industrialized nations, and the coercive nature that many argue is rampant in maternity care, the proposition that the average patient is no longer a RPP when it comes to maternity care is not an unreasonable one.<sup>149</sup> Therefore, it is uncertain whether Ms. Typical can pass the Wisconsin RPP test.

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143. *See id.* (acknowledging that a double mastectomy is an invasive procedure that cannot completely eliminate the chance that a woman will develop breast cancer).

144. *See Schreiber*, 588 N.W.2d at 37 (specifying that new conditions require evolving discussions of informed consent).

145. *See id.* at 34 (arguing that clearly articulated, subjective intent prior to the procedures shifts the standard from an objective standard to a subjective standard).

146. *See Brown*, 595 N.W.2d at 366 (conveying that requiring that the patient be provided with a broad range of information during the informed consent process helps to assure the patient's autonomy).

147. *See id.* at 369 (describing the importance of informed consent in protecting fundamental rights and describing the patient's dependence on the doctor to provide information material to the patient's ability to make an informed decision).

148. *See id.* at 364 (inferring that a reasonably prudent patient will accept some level of risk, particularly depending on the benefits of the procedure).

149. *See DEADLY DELIVERY*, *supra* note 38, at 1, 3, 79 (reporting that maternity care failures in America have risen to the point of human rights violations).

*3. Unless Ms. Typical Receives an Injury Caused by the Administration of the Epidural, She Will Not Have a Cause of Action.*

Under Wisconsin state law, failure to obtain informed consent is a type of medical malpractice, which is a negligence cause of action.<sup>150</sup> Therefore, even though a physician would be in breach of his duty to inform by failing to disclose all of the information required by the statute, a patient would not have a cause of action unless he or she could show a proximate injury.<sup>151</sup> However, Wisconsin courts consider any injury, even normal complications that result from the un-consented procedure, to be a proximate injury.<sup>152</sup> Hence, when the plaintiff in *Brown* suffered disfigurement and discomfort following her double mastectomy, she sustained sufficient injuries to succeed in an informed consent cause of action.<sup>153</sup> Injuries that result from a physician's failure to comply with a patient's request can also sustain an action, as in *Schreiber*, where if the physician had performed the requested Cesarean section at any point during the seven and a half hours following the plaintiff's initial request, the child would have been born healthy.<sup>154</sup>

Here, if Ms. Typical and her child experience no injury as a result of the epidural, she will not have a cause of action.<sup>155</sup> Even if Ms. Typical can unequivocally establish that the statute requires the disclosure of pain management alternatives, that a RPP would have required information about these alternatives to make an intelligent decision, and that a RPP would not have consented to an epidural had she known of the other alternatives, she cannot sustain a claim without a legally recognized injury because informed consent is a negligence action.<sup>156</sup>

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150. See *Schreiber*, 588 N.W.2d at 33 (explaining that failing to ensure informed consent is a negligent act that requires a proximate injury for a cause of action).

151. See *id.* (holding that if plaintiff's daughter had been born healthy, then the plaintiff would not have had a cause of action).

152. See *Brown*, 595 N.W.2d at 365 (finding that plaintiff's disfigurement and pain following the properly performed surgery constituted an injury).

153. See *id.* (indicating that although the case had to be remanded for a new trial, on other grounds, the jury originally awarded the plaintiff \$150,000 in damages).

154. See *Schreiber*, 588 N.W.2d at 32-35 (holding that plaintiff's daughter was born a spastic quadriplegic because she was not delivered prior to plaintiff's uterus rupture, which would not have occurred had the physician ceded to patient's request).

155. See BLOCK, *supra* note 34, at 174-75 (describing how one percent of women may experience a severe spinal headache, but only 1 in 100,000 women might experience severe complications such as death or paralysis).

156. See WIS. STAT. § 448.30 (2011) (describing informed consent as the codification of a physician's duty).

*D. Informational Standing Could Provide a Legally Cognizable Injury and Allow Ms. Typical to Pursue a Cause of Action in Some Jurisdictions.*

Informational standing is a possible mechanism to remedying violations of informed consent that do not result in any injury other than the denial of information and, consequentially, infringe upon the private right of bodily integrity.<sup>157</sup> In *FEC v. Akins*, the plaintiffs were denied information to which they were legally entitled, and the Court speculated that this information would have aided the citizens in making their choice at the polling booth.<sup>158</sup> The FEC was not prohibiting the plaintiffs from voting, but by restricting information the FEC infringed on the plaintiffs' fundamental right enough to constitute an injury-in-fact.<sup>159</sup> By analogy, when a physician does not disclose adequate information for a patient to provide informed consent, that lack of information could constitute a sufficient injury to sustain a legal claim, even if the damages may be nominal, because such a remedy is necessary to protect bodily integrity, a fundamental right.<sup>160</sup> Unlike its common law ancestor medical battery, in which a mere offensive touching without injury constituted a cause of action, lawmakers have codified informed consent as a subset of medical negligence.<sup>161</sup> Thus, if there is no injury, there is no remedy, even if the physician violated the right.<sup>162</sup>

Nevertheless, recognizing an injury will not sustain a cause of action in all three jurisdictions. In New York State, the state statute will still prohibit Ms. Typical from exercising her right of action to recover for lack of informed consent because Ms. Typical is likely to fail all three elements of the informed consent statute, even if the last element, proximate injury, is satisfied.<sup>163</sup> In Washington State, if Washington law recognizes

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157. See Sunstein, *supra* note 33, at 640 (hypothesizing that *FEC v. Akins*, 523 U.S. 11 (1998), could be interpreted to allow Congress to give any citizen standing by creating specific legal interests in the rights any specific legislation intends to protect).

158. See *Akins*, 523 U.S. at 21 (explaining the importance of the information to voters, but nonetheless noting it was unnecessary to support the purpose further because of the clear statutory empowerment of the voters by Congress).

159. See *id.* at 11, 12 (holding the voters passed the testing requirement without overturning the FEC regulations).

160. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 129-30 (N.Y. 1914) (holding that the autonomy to determine what happens to one's own body is a fundamental right, except in the face of an emergency where informed consent cannot be obtained because the patient is unconscious).

161. See Shipley, *supra* note 16 (noting every state has an informed consent statute and violations of the statute are a type of medical malpractice).

162. See *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. Ct. App. 1957) (explaining that disclosing information or withholding information regarding the level of risk of a procedure, when obtaining a patient's informed consent, requires the physician to exercise professional judgment).

163. See *supra* Part III.A (analyzing Ms. Typical's situation under New York State law, showing she lacks a cause of action).

informational standing as an injury, Ms. Typical may be able to prove failure to secure informed consent, but the key issue will be whether she can pass Washington's RPP standard, which cannot be determined conclusively.<sup>164</sup> Finally, under Wisconsin state law, Ms. Typical would likely have a cause of action under Breach of the Physician's Duty to Inform because the only element that she conclusively failed to establish was proximate injury.<sup>165</sup> Informational standing does not unite informed consent with medical battery, but in some jurisdictions, it could prevent the courts from barring legal remedies for informed consent violations that occur without additional injury.

#### IV. POLICY RECOMMENDATION

Despite spending more money on maternity care than any country in the world, America's maternity care system is ranked almost last among industrialized nations.<sup>166</sup> America is one of only four nations with increasing maternal mortality, and American women today are twice as likely to die because of childbirth as their mothers.<sup>167</sup> Society has permitted litigation fears and defensive medicine to coerce women's choices in childbirth, and the outcomes for women have not improved.<sup>168</sup> On principle, coercion is incompatible with patient autonomy and American values, but in practice, it drives a maternity care system that is expensive and poor.<sup>169</sup> Choice and consumerism drive improvement in the marketplace, and healthcare is a market that suffers without choice.<sup>170</sup>

By analyzing three different standards for determining what constitutes a violation of a patient's informed consent rights, clear differences stand out. In states like New York, patients cannot remedy an informed consent failure.<sup>171</sup> So long as a physician is not negligent, a patient cannot sustain

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164. See *supra* Part III.B (analyzing Ms. Typical's situation under Washington law, showing she probably lacks a cause of action).

165. See *supra* Part III.C (analyzing Ms. Typical's situation under Wisconsin law, showing she may have a cause of action).

166. See DEADLY DELIVERY, *supra* note 38, at xx (noting that although the United States' care of severely premature infants is among the best in the world, a woman is seventy percent more likely to die in childbirth in America than in Europe).

167. See *id.* at 4 (noting that of the four world nations with increasing maternal mortality, the United States and Canada stand alone, as Afghanistan has been war torn for ten years, and Norway had a statistically insignificant increase).

168. See GASKIN, *supra* note 46, at 5-7 (describing how physicians can distort information to coerce patient choices).

169. See *id.* (detailing American maternity care costs per capita that are two to three times as high as those in countries of comparable wealth).

170. See, e.g., BLOCK, *supra* note 34, 267-71 (describing the complex interplay of rights and economics in the eighty billion dollar a year maternity care industry).

171. See *DiGeronimo v. Fuchs*, 927 N.Y.S.2d 904, 908 (Sup. Ct. 2011) (upholding the injury requirement even when the medical treatment offends the patient's religious

a cause of action even if a physician intentionally withholds important treatment information; therefore, without an avenue to remedy informed consent violations, New York patients lack a right to informed consent.<sup>172</sup> All states should, instead, follow Washington and Wisconsin in adopting the reasonably prudent patient standard because, in practice, using the reasonable medical provider standards cedes almost absolute discretion to the physician.<sup>173</sup> Though the RPP standard serves an important role for minimizing litigation and allowing hindsight to dictate a patient's priorities after the fact, states like Wisconsin are correct to decline to apply this objective test in the face of clear revocation or clear limitations of consent prior to the treatment.<sup>174</sup>

Bodily integrity, like property rights, depends on exclusivity to define the outer edges of the right.<sup>175</sup> Thus, requiring an injury beyond the invasion of bodily integrity is a troublesome issue that the concept of informational standing could remedy.<sup>176</sup> Just as the *Akins* court held that failing to disclose political information circumscribed suffrage rights, failing to disclose treatment information circumscribes bodily integrity.<sup>177</sup> States should recognize informational standing in this context because it would give plaintiffs the opportunity to sustain a cause of action, which would allow courts to define and defend the right to informed consent.<sup>178</sup>

This Comment used maternity care for its informed consent analysis because maternity care lends itself to comparison and analysis more easily than other aspects of our health care system, but the vulnerabilities of patient autonomy exist in all medical fields.

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beliefs and finding that the patient's emotional distress regarding the blood transfusion did not constitute an injury).

172. See *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 163 (1803) (holding that a right without a remedy is no right at all).

173. See *Cobbs v. Grant*, 502 P.2d 1, 10-12 (Cal. 1972) (holding the physician's disclosure decisions can circumscribe patient autonomy).

174. See *Schreiber v. Physicians Ins. Co. of Wis.*, 588 N.W.2d 26, 34 (Wis. 1999) (stating that applying an objective test in the face of clear revocation of consent could lead to "absurd results").

175. See Hessick, *supra* note 26, at 279-81 (explaining how redress, even through notional damages, protects and defines rights).

176. See *Fed. Election Comm'n v. Akins*, 523 U.S. 11, 12 (1998) (holding that Congress may grant standing to citizens to enforce statutory information disclosure requirements).

177. See *id.* at 21 (concluding that a voter would consider the information at issue before casting his vote).

178. See *supra* Part III.D (explaining that under Wisconsin law, informational standing would likely allow Ms. Typical to sustain a cause of action).

## V. CONCLUSION

Not every important idea or entitlement is a legal right. A legal right requires a legal mechanism to articulate it and a process to remedy infringements upon the right.<sup>179</sup> Informed consent evolved from the common law's recognition that individuals should be the ones that determine what happens to their body, and seeking medical treatment is not a waiver of the right to be free from trespass.<sup>180</sup> As medicine and the law became more sophisticated, informed consent changed from battery to a form of negligence.<sup>181</sup> Physicians gained protection through the development of medical malpractice; by decreasing liability exposure, medical malpractice empowered doctors to use their judgment, which likely brought some benefits to their patients.<sup>182</sup>

However, the classification of informed consent as a type of negligence weakened the right of bodily integrity by requiring an injury beyond the violation of the private right.<sup>183</sup> States should apply the doctrine of informational standing to informed consent because the denial of information circumscribes the right to bodily integrity enough to constitute an injury.<sup>184</sup> In states like New York, informed consent has become an illusory concept with no remedy.<sup>185</sup> Even in patient-centered states like Washington or Wisconsin, informational standing is necessary to ensure plaintiffs can sustain a cause of action for informed consent failures.<sup>186</sup> Liberty requires vigilance in order to preserve or, in some states, take back patient autonomy. Courts and legislatures need to examine their informed consent laws to ensure that individuals have a mechanism to assert their right to bodily integrity because a right without a remedy is no right at all.

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179. See *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 163 (1803) (explaining that a right without a remedy is just an idea).

180. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 129-30 (N.Y. 1914) (articulating that competent adults have an absolute right to be secure in their person).

181. See *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. Ct. App. 1957) (explaining that the disclosure of treatment information is a sensitive matter that requires a physician's discretion).

182. See Halle Fine Terrion, Note, *Informed Choice: Physicians' Duty to Disclose Nonreadily Available Alternatives*, 43 CASE W. RES. L. REV. 491, 497-500 (1993) (discussing the history and therapeutic belief in medicine regarding patient ignorance).

183. See *Salgo*, 317 P.2d at 178-80 (explaining that medical malpractice decreases physicians' liability exposure).

184. See *Cobbs v. Grant*, 502 P.2d 1, 10-12 (Cal. 1972) (discussing how adequate disclosure empowers patient autonomy).

185. See *supra* Part III.A (concluding that there is no stand-alone cause of action for failure to obtain informed consent under New York law).

186. See *supra* Part III.D (explaining that informational standing provides a mechanism for asserting a cause of action because it recognizes the withholding of information as an injury).